Iowa Department of Administrative Services –
Human Resources Enterprise
Workers' Compensation Benefit Election

As the result of an injury on _____, assuming this injury arose out of and in the course of employment, I am entitled to Workers' Compensation benefits, and may choose to supplement these benefits with accrued leave.

My choice is as follows:

Please supplement my Workers' Compensation benefits with my accrued (indicate the order to be used by marking the blank with 1, 2, and 3):

____ Sick Leave
____ Vacation Leave
____ Compensatory Time

____ I decline to supplement my workers' compensation benefits at this time.

(Note: You may choose one option initially, and add additional options later by filling out a new form, but you may not remove options to supplement unless you do so in or before the pay period within which that option would otherwise commence.)

I understand that any supplemental pay over and above my Workers' Compensation Benefit will be subject to all withholding taxes (Federal, State, FICA, and Retirement). I further understand that my accrued leave will be reduced by an amount proportionate to the amount of supplemental pay I receive. My total compensation will not exceed my regular salary.

_____
Signature of employee (or person communicating with the employee)

_____
Date and time of above signature

Complete this form on the fourth day after injury, attach to the "First Report of Injury" and fax to Sedgwick CMS (claims administrator for the State) at (515) 327-4899.

Distribution:

Original to Employee's Department
Copy to Employee
Fax or Copy to Sedgwick CMS

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